Cabinet for Health and Family Services
Office of Health Policy
Data Advisory Subcommittee
Wednesday, December 16, 2009
1:00 PM – 3 PM
CHFS Distance Learning Center

Agenda

I. Welcome and Opening Remarks

II. Approval of Minutes (September 17, 2009)

III. Regulation 900 KAR 7:030 – Data reporting by Health Care Providers

IV. Reports required by statute that have been filed with LRC

V. Report on non-compliant hospitals

VI. Report on the status of the 28 Ambulatory Surgery Centers that need to submit data

VII. Presentation on MONAHRQ

VIII. Annual Hospital Survey – discuss section III, Table 15 – Therapeutic and Diagnostic Cardiac Catheterization Procedures by Facility and Region

IX. Ambulatory Surgery Services Annual Survey – we have received a recommendation that facilities report their Facility Utilization by specific CPT codes rather than the current method

X. Discussion about implementing a person identifier

XI. Update on implementation of data collection services by KHA

XII. Adjourn

Cabinet for Health and Family Services
Office of Health Policy
Data Advisory Subcommittee
Thursday, September 17, 2009
1:00 PM – 3:00 PM
CHFS Auditorium

MEMBERS PRESENT:

James Berton King's Daughters Medical Center	Sherill Cronin, Ph.D. Bellarmine University	Ron Crouch
Carol Ireson University of Kentucky	Tracy Jewell (on behalf of Dr. Dr. Ruth Shepherd) Department for Public Health	Louis Kurtz Dept. for Mental Health Developmental Disabilites, and Addiction Services
Dr. John Lewis	Chuck Warnick Kentucky Hospital Association	Ben Yandell Norton Healthcare

MEMBERS ABSENT:

Tim Marcum
Baptist Hospital East

Paul Sinkhorn

STAFF: CHFS, Office of Health Policy
Carrie Banahan, Kris Hayslett, Sheena Lewis, Allison Martinez, Chandra Venettozzi

Dept. for Mental Health, Developmental Disabilites, and Addiction Services
Hope Barrett

GUESTS: Voin Barker, Office of Insurance
Marie Cull, Cull, Hayden and Vance
Mike Singleton, Kentucky Injury Prevention and Research Center

CALL TO ORDER

Carrie Banahan called the meeting to order in the CHFS Auditorium, Frankfort.

WELCOME AND INTRODUCTIONS

Carrie welcomed the committee and guests.

APPROVAL OF MINUTES

Minutes from the meeting of March 19, 2009, were approved as distributed.

PREVIEW UPDATED TRANSPARENCY WEBSITE

Allison Martinez provided a preview of the updated transparency website. Currently, the Cabinet has 3 years worth of data for the PQIs and IQIs.

DISCUSSION OF CPT CODES

Chuck Warnick surveyed every hospital and ambulatory facility regarding recommendations for additions or deletions to the CPT code list. The recommended changes included removal of surgical codes that are not actually surgical procedures, such as shaving of lesions, surgical preparation, and casts or splints. Recommendations also include the addition of invasive procedures, such as MRI guidance, bone density study or MRI bone marrow blood supply. After discussion, the subcommittee agreed with the recommended changes. The proposed implementation date for the changes is January 1, 2010.

DISCUSS COLLECTION OF RACE/ETHNICITY FROM FREE-STANDING AMBULATORY FACILITIES

The ambulatory surgical centers are having difficulty capturing this information due to patients who are refusing to answer that question. In response to that issue, just for the free-standing ambulatory facilities, 2 new codes will be added stating that the patient refused to answer race and ethnicity. There is also a concern that some of the facilities are using software products that are national products that are not customizable and can not collect race and ethnicity. A new file layout will be created for these facilities that does not include race and ethnicity. Chandra stated that we wanted to get feedback from the subcommittee before moving forward.

900 KAR 7:030 – DATA REPORTING REGULATION – UPCOMING CHANGES

The regulation will be amended to address the race and ethnicity code issue as well as CPT codes that will be added or deleted. It is expected to be filed by either October 15 or November 15.

PROPOSAL FOR NEXT DATA COLLECTION CONTRACT WITH KHA

Carrie stated that the Cabinet is working with KHA to renew the data collection contract for the new biennium.

Ben Yandell introduced the topic of gathering unique identifiers for patients in order to track repeat hospitalizations and multiple utilization of services. Louis Kurtz stated that South Carolina has been successful in this effort. Carrie agreed with the recommendations and said that the Cabinet will do further research.

ADJOURN

The meeting was adjourned at 1:39 p.m.

HEALTHCARE IN KENTUCKY:

A Report of the Operations and Activities of The Cabinet for Health and Family Services Related to Health Data Collection for Hospital Inpatient Discharge and Outpatient Services July 1, 2008 – June 30, 2009

Cabinet for Health and Family Services
Office of Health Policy
September 2009

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Executive Summary

KRS 216.2929 requires "The Cabinet shall at least annually, on or before October 1, submit a report on the operation and activities of the cabinet under KRS 216.2920 to 216.2929 during the preceding fiscal year, including a copy of each study or report required or authorized under KRS 216.2920 to 216.2929 and any recommendations relating thereto." The Office of Health Policy (OHP) within the Cabinet for Health and Family Services (CHFS) has been charged with ensuring compliance with KRS 216.2920 to 216.2929. Therefore, this report is submitted in compliance with this requirement.

Cabinet Secretary's Advisory Committee (SAC)

Pursuant to KRS 216.2923, the Secretary of the Cabinet for Health and Family Services shall appoint and convene a permanent cabinet advisory committee. The committee shall advise the secretary on the collection, analysis, and distribution of consumer-oriented information related to the health care system, the cost of treatment and procedures, outcomes and quality indicators, and policies and regulations to implement the electronic collection and transmission of patient information (e-health) and other cost-saving patient record systems. The committee met three times during the previous year as follows:

1. December 8, 2008 - agenda items: Introduction of new members, overview of purpose of committee, emergency department data submissions, new Ambulatory Facilities will begin data submissions, current status of transparency initiatives (including prevention quality indicators, inpatient quality indicators, and hospital charge information), update from last data advisory subcommittee meeting, and open discussion with committee regarding future transparency initiatives.
2. February 2, 2009 - agenda items: Preview new Inpatient Quality Indicator website, responses to questions from previous meeting, emergency department data submissions update, report on non-compliant facilities, and status of new Ambulatory Facility data submissions.
3. April 28, 2009 - agenda items: Presentation of draft emergency department utilization report, status of data reporting for new Ambulatory Facilities, status of data reporting regulation, funding for future emergency department data collections, and status of Prevention Quality Indicator reports using 2007 data.

Health Services Data Advisory Subcommittee (DAS)

KRS 216.2923 also specifies that the cabinet advisory committee shall utilize the Health Services Data Advisory Committee as a subcommittee to advise the cabinet on technical matters, including a review of administrative regulations, proper interpretation of the data, and the most cost-efficient manner in which it should be published and disseminated to the public, state and local leaders in health policy, health facilities, and health-care providers. The committee met three times during the year as follows:

1. August 27, 2008 - agenda items: Introduction of Office of Health Policy Executive Director; report by Chuck Warnick with the Kentucky Hospital Association of 2008 1st quarter data collection activities; Methicillin Resistant Staphylococcus Aureus (MRSA) collaborative meeting overview; 902 KAR 19:020 Release of Public Data Sets for Health Care Discharge Data Regulation; presentation by Dr. Kevin Kavanagh with Kentucky Health Watch regarding adverse events in hospitals, value index for hospitals, and the healthcare transparency & patient advocacy conference; and subcommittee membership.
2. December 15, 2008 - agenda items: Proposed changes to 902 KAR 19:020 – Data reporting regulation, reporting for new Ambulatory Facilities, corrective action plans for facility non-compliance for 1st and 2nd quarter 2008, status of annual survey submission, and recommendations for reports/uses for new emergency department data.
3. March 19, 2009 - agenda items: Update on Secretary's Advisory Committee on Transparency, debut of new Inpatient Quality Indicator web site, 900 KAR 7:030 – Data reporting regulation, presentation of draft emergency department utilization report.

Health Care Information Center

KRS 216.2923 requires that the Cabinet publish and make available information on charges for health care services and the quality and outcomes of health care services. KRS 216.2929 also requires CHFS to make available on its web site information on charges for health care services at least annually in understandable language with sufficient explanation to allow consumers to draw meaningful comparisons between every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups as relevant data becomes available.

In response to these requirements, a web site was developed by the Office of Health Policy with information on Inpatient Quality Indicators and Prevention Quality Indicators using measures from the Agency for Healthcare Research and Quality (AHRQ). The web site includes a link to hospital charge information provided by the Kentucky Hospital Association and a link to the U.S. Department for Health and Human Services' Hospital Compare web site for quality measure comparisons. It also contains links to the federal government's internet home for information and resources related to health care transparency and value-driven health care. Data about the Inpatient Quality Indicators, Prevention Quality Indicators, and hospital charge information are updated annually to include the most recent year's data available. The web page may be accessed at http://chfs.ky.gov/ohp/healthdata/ .

Legislation

No legislative changes have occurred during the past year.

Administrative Regulations

KRS 216.2927 requires that the Cabinet for Health and Family Services shall make all aggregate data which does not allow disclosure of the identity of any individual patient available to the public. Persons requesting use of the data shall agree to abide by a public-use data agreement and by HIPP privacy rules referenced in 45 C.F.R. Part 164. An amendment was required to 902 KAR 19:030 to incorporate by reference an updated public-use data agreement which contained only technical changes. During the 2008 data collection period, a new data-element, MS-DRG (Medicare Severity Diagnosis Related Group), was added. Therefore, the regulation also needed to be amended to include this data element in the public use data set. The Kentucky Hospital Association participated with the Office of Health Policy in drafting language for the amendment.

Response to Requests for Summary Data and Reports

The following list is representative of summaries and reports that have been requested and disseminated during fiscal year 2008-2009. Many of these summaries and reports were created in response to requests from researchers, policy makers, and the general public, while others were created at the request of other agencies within the Cabinet for Health and Family Services. The following summaries and reports were generated by the Office of Health Policy using the Kentucky Inpatient Discharge data and the Outpatient Services data (the requesting party is listed in parentheses).

1. Inpatient Hospitalization days by facility and payor type of Medicaid, Medicare, or other; 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
2. Inpatient Hospital leading twenty-five DRGs by facility Area Development District, 2008 Annual Hospital Utilization Services Report (B. Morris, Office of Health Policy, CHFS)
3. Inpatient Hospital facility activity by quarter, by facility Area Development District, and by patient residency, gender, age group, admission type, length of stay, and primary payor, 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
4. Inpatient Hospital leading twenty-five MS-DRGs by facility Area Development District, 2008 Annual Hospital Utilization Services Report (B. Morris, Office of Health Policy, CHFS)
5. Emergency Department Utilization by facility and payor type of Medicaid, Medicare, or other: 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
6. Emergency Department facility activity by facility Area Development District, by quarter and by patient residency, gender, age group, type of service, month of service, and primary payor, 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
7. Emergency Department leading twenty-five principal diagnoses by facility Area Development District, 2008 Annual Hospital Utilization Services Report (B. Morris, Office of Health Policy, CHFS)
8. Number of Suicide and Self Inflicted Injury Inpatient Hospital Discharges by Gender – 2005 through September, 30 2008. (A. Wilburn, Department of Public Health, CHFS)

9. Psychiatric Diagnosis Inpatient Hospitalizations by Facility, County of Residence, and Principal Diagnosis 2004 to 2007. (B. Burns, CHFS)
10. Heart Disease Diagnosis Inpatient Hospitalizations by year, gender, age group, and principal diagnosis group 2001 to 2007. (Dr. Benjamin Horne, Department of Biomedical Informatics, University of Utah)
11. Emergency Department and Observation Stay visits by Payor, January 2008 to June 2008. (B. Johnson, Department of Medicaid Services, CHFS)
12. Detailed Emergency Department and Observation Stay report from January 2008 to June 2008. (C. Banahan, Office of Health Policy, CHFS)
13. Inpatient procedures at northern Kentucky hospitals. (C. Banahan, Office of Health Policy, CHFS)
14. Psychiatric inpatient discharges over age 65 by payor, 2007. (C. Banahan, Office of Health Policy, CHFS)
15. Mammograms by county in 2007. (C. Banahan, Office of Health Policy, CHFS)
16. Inpatient discharges by payor by county for births and low-birth weight births during 2006. (D. Jacovitch, Cabinet for Health and Family Services)
17. Inpatient Hospitalizations as a result of Injury and Poisoning by Discharge Status, 2007. (Dr. Steven Spady)
18. Influenza and Pneumococcal Pneumonia Inpatient Hospitalizations by Admission Source and Age, 2007. (Dr. K. Humbaugh, Department for Public Health, CHFS)
19. Wenener's Granulomatosis Diagnosis Inpatient Hospitalizations by year, 2004 to 2007. (Dr. Frank Groves, School of Public Health and Information Sciences, University of Louisville)
20. Rate of Hip Fractures in 2007 per 1,000 women age 65 and over. (J Grider, Department for Public Health, CHFS)
21. Hernia Inpatient Hospitalizations, 2006 and 2007. (J. Brandon)
22. Inpatient hospitalizations and Total Billed Charges for Low birth Weight by Payor, 2006. (J. Robl, Department for Public Health, CHFS)
23. Inpatient hospitalizations by facility for malignant neoplasm, 2007. (M. Herrler, Wise Global Consulting)
24. Inpatient hospitalizations by facility for non-malignant neoplasm, 2007. (M. Herrler, Wise Global Consulting)
25. Inpatient Hospitalizations by Area Development District for STEMI, 2007. (S. Block, American Heart Association/American Stroke Association)
26. Average billed charges for a hospital visit in 2007. (S. Robeson, Department for Public Health, CHFS)
27. Asthma Hospitalizations for children age 0 to 17, 2000-2002, 2004-2006, 2005-2007. (P. Tennen, Kentucky Youth Advocates)
28. Asthma Hospitalizations for children age 0 to 4, 2007. (T. Jewell, Department for Public Health, CHFS)
29. Inpatient Hospitalizations for non-fatal injuries to children age 15 or less. (T. Jewell, Department for Public Health, CHFS)
30. Inpatient Hospitalizations due to excessive heat and cold, 2006 and 2007. (W, Gunnels, Senator Bernie Sanders Office)
31. COPD Hospitalizations by County vs. Gender, 2006 – 2007 Hospital Discharge Data (C. Buckley, Public Health)

32. COPD Hospitalization Charge Data by Gender, 2006 – 2007 Hospital Discharge Data (C. Buckley, Public Health)
33. COPD Hospitalizations by Age Groups vs. Gender, 2006 – 2007 Hospital Discharge Data (C. Buckley, Public Health)
34. Asthma Hospitalization Rates by ADD, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
35. Asthma Hospitalization Rates by ADD vs. Age Groups, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
36. Asthma Hospitalization Rates by Counties, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
37. Asthma Hospitalization Rates by Counties vs. Age Groups, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
38. COPD Hospitalization Rates by County, 2006 - 2008 Hospital Discharge Data (K. Nunn, Public Health)
39. COPD Hospitalization Rates by County vs. Age Groups, 2007 Hospital Discharge Data (K. Nunn, Public Health)
40. COPD Hospitalization Rates by Age Groups, 2007 Hospital Discharge Data (K. Nunn, Public Health)
41. Blastomycosis Hospitalizations, 2005 – 2008 Hospital Discharge Data (E. Lutterloh, Public Health)
42. Sunburn Related Hospitalizations, 2008 Inpatient and Outpatient Discharge Data (B. Fisher, Communications)
43. Cardiac Catheterizations, Adults 18 and Older, 2008 Inpatient Discharge Data (A. Kirsch)
44. Cardiac Catheterizations, Adults 18 and Older, 2008 Outpatient Discharge Data (A. Kirsch)
45. Cardiovascular Disease Hospitalizations by County with Charge Data, 2007 – 2008 Hospital Discharge Data (B. Bobo, Public Health)
46. Heart Disease Hospitalizations by County with Charge Data, 2007 – 2008 Hospital Discharge Data (B. Bobo, Public Health)
47. Stroke Hospitalizations by County with Charge Data, 2007 – 2008 Hospital Discharge Data (B. Bobo, Public Health)
48. Flu Related Discharge Data, 2005 – 2008 Hospital Discharge Data (E. Lutterloh, Public Health)
49. Pelvic Inflammatory Disease Hospitalizations by Year and Quarter, with Total Charges and Patient Days, 2005 – 2008 Hospital Discharge Data (S. White, Public Health)
50. Juvenile Hospitalizations with Charge Data, 2007 – 2008 Hospital Discharge Data (C. Banahan, Office of Health Policy)
51. Catheterizations or CABGs by Facility, Patient Origin, 2007 Hospital Discharge Data (C. Banahan, Office of Health Policy)
52. Average Length of Stay (ALOS) for Hospitalizations by DRG, 2007 – 2008 Hospital Discharge Data (C. Banahan, Office of Health Policy)
53. Hospitalizations by DRG with Length of Stay Greater than ALOS, by Age Groups, 2007 – 2008 Hospital Discharge Data (C. Banahan, Office of Health Policy)

Public Use Data Sets

The Office of Health Policy creates public use data sets for each calendar year for inpatient discharges and for outpatient services (ambulatory surgery and mammograms), which are available for purchase by interested parties for $1,500 each. Complete or partial data sets are provided to qualified researchers or other state agencies free of charge. Both the inpatient discharge data set and the outpatient services data set are also provided to the Healthcare Cost and Utilization Project (H-CUP), a nationwide health data collection and analysis effort sponsored by the Agency for Healthcare Research and Quality (AHRQ). Inpatient discharge data are included in H-Cup's Nationwide Inpatient Sample (NIS), together with similar data from thirty-seven other H-CUP partner states. Data from these state inpatient databases are also extracted and included in H-CUP's Kids' Inpatient Database (KID). As part of this project, Kentucky inpatient data is included in H-CUPnet, an interactive, web-accessible service which enables public access and comparison of H-CUP state partner data. Kentucky is also one of 27 state contributors of outpatient services (ambulatory surgery) data to H-CUP's State Ambulatory Surgery Data base.

Prior to receiving a public use data set, an Agreement for Use of Kentucky Health Claims Data Agreement must be signed. This agreement was modeled after a similar document used by the H-CUP project and has been approved by the Health Services Data Advisory Committee. This agreement prohibits the recipients from selling raw or summary data and tasks the recipient with maintaining the confidentiality of the data.

During this reporting period, the Office of Health Policy received $25,500 from the sale of Public Use Data Sets.

The following list of Public Use Data Set users illustrates the diversity of application of Kentucky hospital discharge data and outpatient services data.

1. Inpatient discharge data set, 2006, 2007, 2008, (B. Kimball and W. Mark Twilla, Cabell Huntington Hospital)
2. Inpatient discharge data set, 2007 (D. Baker, Aspen Healthcare Metrics)
3. Eleven sets of Kentucky's public use inpatient data and outpatient services files were also purchased for various activities through H-CUP Project's Central Distributor.

HEALTHCARE IN KENTUCKY:

The Cabinet for Health and Family Services Biennial Report on Health Care Transparency

July 1, 2007 – June 30, 2009

Cabinet for Health and Family Services
Office of Health Policy
September 2009

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Executive Summary

KRS 216.2929 requires "The Cabinet shall at least biennially, no later than October 1 of each odd-numbered year, report on matters pertaining to comparative health-care charges, quality, and outcomes, the effectiveness of its activities relating to educating consumers and containing health-care costs, and recommendations regarding its data collection and dissemination activities." The Office of Health Policy (OHP) within the Cabinet for Health and Family Services (CHFS) has been charged with ensuring compliance with KRS 216.2920 to 216.2929. Therefore, this report is submitted in compliance with this requirement.

Health Care Information Center (Also referred to as the "Transparency" Web Site)

KRS 216.2923 requires that the Cabinet publish and make available information on charges for health care services and the quality and outcomes of health care services. KRS 216.2929 also requires CHFS to make available on its Web site information on charges for health care services at least annually in understandable language with sufficient explanation to allow consumers to draw meaningful comparisons between every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups as relevant data becomes available.

In response to these requirements, a web site was developed by the Office of Health Policy (OHP) that provides information regarding Inpatient Quality Indicators and Prevention Quality Indicators using measures from the Agency for Healthcare Research and Quality (AHRQ). The web page may be accessed at http://chfs.ky.gov/ohp/healthdata/ .

Charges for Health Care Services

The OHP web site includes a link to hospital charge information provided by the Kentucky Hospital Association. Data is provided based on Medicare Severity-Diagnosis Related Group (MS-DRG) for years 2006, 2007, and 2008. Results are displayed by hospital and provide number of discharges, median charges, 10^{th} percentile charges, 90^{th} percentile charges, average length of stay, and average age of the patient. Hospitals with less than 20 discharges for the specified MSDRG are excluded as the sample size is considered too small to represent statistically reliable results.

Quality and outcomes of Health Care Services

The OHP web site includes information about quality and outcomes via Inpatient Quality Indicators and a link to the U.S. department for Health and Human Services' Hospital Compare web site.

Hospital Compare was created through the efforts of the Centers for Medicare and Medicaid Services (CMS) along with members of the Hospital Quality Alliance. Hospital Compare has quality measures on how often hospitals provide some of the recommended treatments to get the best results for most patients. The web site provides a tool to determine how well hospitals care for patients with certain medical conditions or surgical procedures, and include results from a survey completed by patients about the quality of care they received during a recent hospital stay. The information on the web site comes from hospitals that have agreed to submit quality information to CMS.

A search may be conducted by hospital name, within a certain distance of a zip code, city, state, or county. After entering search criteria, information about medical conditions includes: heart attack; heart failure; chronic lung disease; pneumonia; diabetes in adults; and chest pain; and information about surgical procedures including: heart and blood vessels; abdominal; bladder, kidney, and prostate; female reproductive; and neck, back, and extremities. Results of a search will display the following:

- General information about the hospital such as name, address, telephone number, type of hospital, and if emergency services are provided.
- (If available) - Hospital process of care measures, hospital outcome of care measures, and survey of patients' hospital experiences. Examples of process of care measures are: percent of heart attack patients given aspirin at arrival, percent of pneumonia patients given oxygenation assessment, percent of heart failure patients given smoking cessation advice/counseling. An example of outcome of care measures is Death Rate of Heart Attack Patients. Survey of patients' hospital experiences may include: percent of patients who reported that their nurses "always" communicated well, percent of patients who reported that their pain was "always" well controlled, or percent of patients who reported that their room and bathroom were "always" clean.
- The average Medicare Payment of the hospital for the specified diagnosis related group (DRG), and the number of Medicare Patients Treated.

Inpatient Quality Indicators were created using Inpatient Quality Indicator (IQI) software developed by the Agency for Health Care Research and Quality and the Department for Health and Human Services. IQIs provide a measure of quality for specific medical conditions and surgical procedures performed in a Kentucky hospital. The data used to develop the IQI reports are standardized administrative information routinely submitted by Kentucky hospitals to bill for services. To fairly report on the quality of inpatient care, the data are risk-adjusted to account for differences in patient acuity or severity levels for each facility. The site contains quality indicators related to inpatient mortality for medical conditions, inpatient mortality for surgical procedures, and utilization of procedures for which there are questions of overuse, under use, or misuse. *Inpatient mortality for medical conditions* including the following:

- Acute Myocardial Infarction (Heart Attack) Mortality Rate
- Congestive Heart Failure (CHF) Mortality Rate
- Acute Stroke Mortality Rate
- Gastrointestinal Hemorrhage (Bleeding in the Digestive Tract) Mortality Rate
- Hip Fracture Mortality Rate
- Pneumonia Mortality Rate

- Cartoid Endarterectomy Mortality Rate
- Acute Myocardial Infarction, Without Transfer Cases (Heart Attack cases excluding transfer cases) Mortality Rate

Inpatient mortality for surgical procedures includes the following:

- Abdominal Aortic Aneurysm Repair Mortality Rate
- Coronary Artery Bypass Graft (CABG-Heart Surgery) Mortality Rate
- Craniotomy (Brain Surgery) Mortality Rate
- Laparoscopic Cholecystectomy (Gallbladder Surgery) Mortality Rate
- Percutaneous Transluminal Coronary Angioplasty (PTCA) Mortality Rate

Utilization of procedures for which there are questions of overuse, under use, or misuse include the following:

- Cesarean Delivery Rate
- Vaginal Birth After Cesarean Delivery Rate, Uncomplicated
- Incidental Appendectomy in the Elderly Rate
- Bilateral Cardiac Catheterization Rate
- Primary Cesarean Delivery Rate
- Vaginal Birth After Cesarean (VBAC) Delivery, All

Each mortality indicator report provides a description of the medical condition or surgical procedure, a link to the medical definition, a link to a technical definition, the national rate, and the state risk adjusted rate. The results display the name of every hospital performing at least 20 of the procedures with the total number of procedures and the number of cases where death occurred. The risk adjusted rate for each hospital is then compared to either the national rate or state rate (whichever was selected for comparison) and the hospital rate is displayed in red if it is significantly worse than the comparison rate, green if it is significantly better than the comparison rate, and black if it is comparable to the comparison rate.

Each utilization indicator report provides a description of the selected indicator, a link to the medical definition, a link to a technical definition, the national rate, and the state risk adjusted rate. The results display the name of every hospital performing at least 20 of the specified IQIs with the total number of procedures and the number of cases with the specified outcome. The results may also be displayed in a graph.

The Office of Health Policy web site now contains data for three federal fiscal years: October 1, 2005 to September 30, 2006; October 1, 2006 to September 30, 2007; and October 1, 2007 to September 30, 2008. An additional year's data is added annually when it becomes available.

Prevention Quality Indicators were created using Prevention Quality Indicator (PQI) software developed by the Agency for Health Care Research and Quality and the Department for Health and Human Services. PQIs are a set of measures that can be used to identify "ambulatory care sensitive conditions," which are conditions for which good outpatient care can potentially prevent the need for hospitalization, complications, or more severe disease. The data used to develop the PQI reports are also standardized administrative information routinely submitted by

Kentucky hospitals to bill for their services, and are risk-adjusted to account for the difference in patient severity levels. PQIs are presented as a percentage rate of population over age 18 or as a percentage rate of total admissions for the specified condition. Overall, Acute, and Chronic composite indicators are also available.

PQIs presented as a percentage rate of population over age 18 are:

- Diabetes short-term complication admission rate
- Diabetes long-term complication admission rate
- Chronic obstructive pulmonary disease admission rate
- Hypertension admission rate
- Congestive heart failure admission rate
- Dehydration Admission rate
- Bacterial pneumonia admission rate
- Urinary tract infection admission rate
- Angina admission without procedure
- Uncontrolled diabetes admission rate
- Adult asthma admission rate
- Rate of lower – extremity amputation among patients with diabetes

PQIs presented as a percentage rate of total admissions for the specified conditions are:

- Perforated appendix admission rate
- Low Birth Weight

Results for each PQI are displayed on a Kentucky map with each county colored in red, yellow, or green. Green indicates an area with a risk-adjusted rate (considering a margin of error) that is lower than the national average for that indicator. Yellow indicates an area with a risk-adjusted rate (considering a margin of error) that is comparable to the national average. Red indicates an area with a risk-adjusted rate (considering a margin of error) that is above the national average. For Prevention Quality Indicators, lower rates usually represent better outpatient care which can potentially prevent the need for hospitalization.

The web site now contains data for three calendar years: 2006, 2007, and 2008. An additional year's data is added annually when it becomes available.

The effectiveness of activities relating to educating consumers and containing health-care costs

As indicated above, the OHP web site provides a wealth of health care information related to charges, services, and quality. This information is used by hospitals, consumers, researchers, health departments, other state agencies, and policy makers as an effective means of education and decision making. Information about incidence of disease and outcomes is used by these entities for education as well as decisions that can help contain health-care costs. Consumers use the Inpatient Quality Indicators to help determine the outcomes for specific providers and to determine the costs for specific diagnoses. Policy makers and health departments use the Prevention Quality Indicators in their research and decision making.

Recommendations regarding data collection

The Office of Health Policy would recommend one change to the Commonwealth's present data collection process. Currently, the statute prohibits the collection of individually identifying information regarding patients. Therefore, any analysis completed is based on the number services provided rather than the number of patients served. For comparison purposes in analysis, results are usually stated as a number per 100,000 population.

- For example, county A may have had 437 emergency department visits per 100,000 population and county B had 374 emergency department visits per 100,000 population. The analysis would indicate that residents in county A utilized services in an emergency department 14.37% less frequently than county B. However, without a patient identifier this statement may not be accurate because the number of patients actually seen in an emergency department is unknown.
- For discussion purposes, that county A actually had 325 emergency department patients per 100,000 population and county B had 330 emergency department patients per 100,000 population. In this instance, county B would have utilized services more than county A.

The current analysis is valuable, but accurate counts of patients served as opposed to visits provided would prove to be far more valuable.

Patient identifiers would also be extremely useful in tracking hospital re-admissions to analyze the reasons patients were re-admitted to the hospital. Currently this is not possible. OHP would not identify who the patient is, but would utilize an identifier to track the services received by patients.

OHP is considering the addition of Patient Safety Indictors (PSI) on its web site. PSIs are a set of indicators that include 27 measures providing information on hospital complications and adverse events following surgeries, procedures, and childbirth and serve as a tool to help health system leaders identify potential adverse events occurring during hospitalization.. The indicators were developed by the Agency for Healthcare Research and Quality after a comprehensive literature review, analysis of the ICD-9-CM codes, review by a clinical panel, implementation of risk adjustment, and empirical analyses.

Other Information available on the Office of Health Policy web site

A link to the federal government's internet home for information and resources related to health care transparence and value-driven health care is also provided.

SC ORS UNIQUE ID PROCESS OVERVIEW

The purpose of this document is to give a general overview of how the unique ID number process works. While there are some differences in the process between how newborn records are handled versus non-newborn records, this overview will not specifically explain these details. Specific details are omitted.

The technical foundation for integrating data is a successful key linker system. South Carolina began "unduplicating" at the person level using all personal identifiers starting with the1996 data. Each unduplicated person is assigned a random number generated by a computer program algorithm. This number is commonly referred to as the Unique ID or Key Linker. The algorithm uses personal identifiers that include, but are not limited to: SSN, first name, middle initial, last name, date of birth, race, and gender. The data is cleaned (i.e., characters are removed from SSN, dates are compared to valid ranges) and standardized (i.e., all characters are converted to uppercase) before being run through the algorithm.

All of the cleaned/standardized identifier fields on a record are compared to existing records for exact or partial matches. A 'MatchType' is then assigned for each potential match. The 'matchtype' is a string of characters that represent the match for a certain field. For example, SSN can be an exact match, one digit different, two digits transposed, shifted one position to the left or right or shifted two positions to the left or right. A 'MatchScore' (the rate indicating how often this 'MatchType' yields the same person) and a'FieldScore' (the number indicating the strength of the fields that matched) is then assigned to the record. Records with a 'MatchScore' below a determined threshold of 60% are immediately discarded as not being the same person.

For each individual original record for which there are records with a MatchScore of 90 or greater, a single record is chosen as the actual match using a hierarchy of specified criteria. Once that single record match is chosen, the unique ID number from the matched record is assigned. If no records for a given original record have a MatchScore of 90 or greater, all candidates for that original record are kept to combine with more possible candidates determined in more 'fuzzy' matches. The process of scoring is then repeated for all records in the pool.

The algorithm accounts for misspelling, name changes, transposed digits in the social security number, and slight differences in the date of birth. The unique ID is in no way affiliated with an identifier associated with an individual, i.e., social security number or date of birth. An individual's Unique ID stays with them on all subsequent episodes of services, regardless of data source or service provider.

For each additional record, public or private, submitted to the ORS, a comparison is made to the "unduplicated" person file. If that individual is found, then the designated key linker is assigned to that episode of service. If that individual is not found, then he or she is added to the unduplicated file and assigned Unique ID. During this process, an individual's personal identifiers are never associated with the service received in order to protect confidentiality. The final statistical file contains no personal identifiers, only the Unique ID, which is not related to anything about the person.

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TITLE 44. HEALTH

CHAPTER 6. STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION

ARTICLE 2. MEDICALLY INDIGENT ASSISTANCE ACT

SECTION 44-6-170. Collection and release of health care related data; confidentiality; regulations to be promulgated; Data Oversight Council; Health Data Analysis Task Force; hospitals to provide required information; violations and penalties. [SC ST SEC 44-6-170]

(A) As used in this section:

(1) "Office" means the Office of Research and Statistics of the Budget and Control Board.

(2) "Council" means the Data Oversight Council.

(3) "Committee" means the Joint Legislative Health Care Planning and Oversight Committee.

(B) There is established the Data Oversight Council comprised of:

(1) one hospital administrator;

(2) the chief executive officer or designee of the South Carolina Hospital Association;

(3) one physician;

(4) the chief executive officer or designee of the South Carolina Medical Association;

(5) one representative of major third party health care payers;

(6) one representative of the managed health care industry;

(7) one nursing home administrator;

(8) three representatives of nonhealth care-related businesses;

(9) one representative of a nonhealth care-related business of less than one hundred employees;

(10) the executive vice president or designee of the South Carolina Chamber of Commerce;

(11) a member of the Governor's office staff;

(12) a representative from the Human Services Coordinating Council;

(13) the director or his designee of the South Carolina Department of Health and Environmental Control;

(14) the executive director or his designee of the State Department of Health and Human Services;

(15) the chairman or his designee of the State Health Planning Committee created pursuant to Section 44-7-180.

The members enumerated in items (1) through (10) must be appointed by the Governor for three-year terms and until their successors are appointed and qualify; the remaining members serve ex officio. The Governor shall appoint one of the members to serve as chairman. The office shall provide staff assistance to the council.

(C) The duties of the council are to:

(1) make periodic recommendations to the committee and the General Assembly concerning the collection and release of health care-related data by the State which the council considers necessary to assist in the formation of health care policy in the State;

(2) convene expert panels as necessary to assist in developing recommendations for the collection and release of health care-related data;

(3) approve all regulations for the collection and release of health care-related data to be promulgated by the office;

(4) approve release of health care-related data consistent with regulations promulgated by the office;

(5) recommend to the office appropriate dissemination of health care-related data reports, training of personnel, and use of health care-related data.

(D) The office, with the approval of the council, shall promulgate regulations in

accordance with the Administrative Procedures Act regarding the collection of inpatient and outpatient information. No data may be released by the office except in a format recommended by the council and consistent with regulations. Before the office releases provider identifiable data the office must determine that the data to be released is for purposes consistent with the regulations as promulgated by the office and the release must be approved by the council and the committee. Provided, however, committee approval of the release is not necessary if the data elements and format in the release are substantially similar to releases or standardized reports previously approved by the committee. The council shall make periodic recommendations to the committee and the General Assembly concerning the collection and release of health care-related data by the State. Regulations promulgated by the office mandating the collection of inpatient or outpatient data apply to every provider or insurer affected by the regulation regardless of how the data is collected by the provider or insurer. Every effort must be made to utilize existing data sources.

(E) Information may be required to be produced only with respect to admissions of and treatment to patients after the effective date of the regulations implementing this section, except that data with respect to the medical history of the patient reasonably necessary to evaluation of the admission of and treatment to the patient may be required.

(F) The office shall convene a Health Data Analysis Task Force composed of technical representatives of universities and other private sector and public agencies including, but not limited to, health care providers and insurers to make recommendations to the council concerning types of analyses needed to carry out this section.

(G) All general acute care hospitals and specialized hospitals including, but not limited to, psychiatric hospitals, alcohol and substance abuse hospitals, and rehabilitation hospitals shall provide inpatient and financial information to the office as set forth in regulations.

All hospital-based and freestanding ambulatory surgical facilities as defined in Section 44-7-130, hospital emergency rooms licensed under Chapter 7, Article 3, and any health care setting which provides on an outpatient basis radiation therapy, cardiac catherizations, lithotripsy, magnetic resonance imaging, and positron emission therapy shall provide outpatient information to the office as set forth in the regulation. Other providers offering services with equipment requiring a Certificate of Need shall provide outpatient information to the office. Additionally, licensed home health agencies shall provide outpatient information to the office as set forth in the regulation.

Release must be made no less than semiannually of the patient medical record information specified in regulation to the submitting hospital and other information specified in regulation to the hospital's designee. However, the hospital's designee must not have access to patient identifiable data.

(H) If a provider fails to submit the health care data as required by this section or Section 44-6-175 or regulations promulgated pursuant to those sections, the Office of Research

and Statistics may assess a civil fine of up to five thousand dollars for each violation, but the total fine may not exceed ten thousand dollars.

(I) A person, as defined in Section 44-7-130, seeking to collect health care data or information for a registry shall coordinate with the office to utilize existing data collection formats as provided for by the office and consistent with regulations promulgated by the office. With the exception of information that may be obtained from the Office of Vital Records, Department of Health and Environmental Control, in accordance with Section 44-63-20 and Regulation 61-19 and disease information required to be reported to the Department of Health and Environmental Control under Sections 44-29-10, 44-29-70, and 44-31-10 and Regulations 61-20 and 61-21 and notwithstanding any other provision of law, no hospital or health care facility or health care professional required by this section to submit health care data is required to submit data to a registry which has not complied with this section.

SECTION 44-6-180. Confidentiality of patient records; controlled dissemination of data; violations and penalties. [SC ST SEC 44-6-180]

(A) Patient records received by counties, the department, or other entities involved in the administration of the program created pursuant to Section 44-6-150 are confidential. Patient records gathered pursuant to Section 44-6-170 are also confidential. The division shall use patient-identifiable data collected pursuant to Section 44-6-170 for the purpose of linking various data bases to carry out the purposes of Section 44-6-170. Linked data files must be made available to those agencies providing data files for linkage. No agency receiving patient-identifiable data collected pursuant to Section 44-6-170 may release this data in a manner such that an individual patient or provider may be identified except as provided in Section 44-6-170. Nothing in this section may be construed to limit access by a submitting provider or its designee to that provider's information.

(B) A person violating this section is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than one year, or both.

ARTICLE 8.

DATA REPORTING REQUIREMENTS PERTAINING TO SOUTH CAROLINA HOSPITALS

(Statutory Authority: 1976 Code Sections 44-6-170, 44-6-175 and 44-6-200, as amended)

19-800. Definitions.

Hospitals: is as defined in South Carolina State Certification of Need and Health Facility Licensure Act, Section 44-7-130.
Calendar quarter: is defined as any one of the following: January through March, April through June, July through September, and October through December.
Discharged Patient: is any patient admitted to a hospital for inpatient services or any maternal delivery or newborn service.

19-801. Financial and Utilization Data (Annual).

A. All required items shall be reported to the Office of Research and Statistics, South Carolina Budget and Control Board, for the period October first through September thirtieth by March first of the following year.
B. The formats for submission of the required items are:
(1) "Annual Hospital Financial Data Report" or other format as specified by the Office of Research and Statistics for financial items;
(2) "Joint Annual Report of Hospitals" or other format as specified by the Office of Research and Statistics for utilization items.
C. When a format other than the Annual Report in B(1) or B(2) above is specified, the Office of Research and Statistics shall provide the format to hospitals thirty days prior to implementation of that format.
D. Financial data elements pertaining to patient charges shall be reported for "inpatients only" and for "all patients, inpatients and outpatient."
E. The financial and utilization data elements to be collected are:
(1) Gross patient revenue;
(2) Gross revenue from Medicare;
(3) Gross revenue from Medicaid;
(4) Gross revenue from Medically Indigent Assistant Program;
(5) Government contractual adjustments for:
(a) Medicare;
(b) Medicaid;
(c) Medically Indigent Assistant Program;
(d) TriCare; and
(e) Other Contractual Allowances;
(6) Total direct costs of medical education:
(a) Reimbursed, and
(b) Unreimbursed;
(7) Total indirect costs of medical education:
(a) Reimbursed, and
(b) Unreimbursed;
(8) Total costs of care for medically indigent:
(a) Reimbursed, and
(b) Unreimbursed;
(9) Bad debt expenses, net of recovery;
(10) Total patient days;

(11) Average length of stay;
(12) Total outpatient visits.
F. Hospitals shall submit to the Office of Research and Statistics a copy of their "Medicare Cost Reports" in accordance with the submission requirements of the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services.
G. Hospitals shall maintain documentation to substantiate all items governed by R.19.801 for a period of three years from the March first deadline date.

19-810. Medical Record Extract Information.

A. The data elements will be specified by the Data Oversight Council through Principles and Protocol for the Release of Health Care Data. The Principles and Protocol for the Release of Health Care Data shall allow for review and input by interested parties on the data elements to be reported taking into consideration all applicable federal, state laws and regulations. The Data Oversight Council will rely, to the extent possible, on data elements currently being reported among health care entities.
B. Patient records submitted shall be in accordance with, but not limited to the specifications, promulgated by the Secretary of the Department of Health and Human Services for the United States of America in accordance with the authority to designate health care codes and transactions under the Health Insurance Portability and Accountability Law of 1996, as well as under the specifications of the Director of the Centers for Medicare and Medicaid Services and as specified in the Medically Indigent Assistance Act for the State of South Carolina.
C. Records shall be submitted directly to the Office of Research and Statistics on magnetic media or via some other system made available by the Office of Research and Statistics in a format to be specified by the Office of Research and Statistics and provided to hospitals one hundred twenty days prior to implementation of that format.
D. One record for each inpatient discharged during the calendar month (including newborns) shall be submitted. Hospitals shall submit at least ninety percent of their monthly discharge records within forty-five days after the close of the month with exception made for conditions beyond the hospital's control. Hospitals shall submit one hundred percent of their discharge records within forty-five days after the close of the following month with exception made for conditions beyond the hospital's control.
E. Reporting of required items shall meet ninety-nine percent item completeness.
F. Completed items shall meet ninety-nine and five tenths percent accuracy as determined by edit specifications set by the Office of Research and Statistics.
G. Hospitals changing hardware/software or processors, which would necessitate a change in tape submission procedure, shall:
(1) Notify the Office of Research and Statistics in writing at least sixty days prior to change and submit a test tape meeting completeness and accuracy requirements within one hundred twenty days after the change is accomplished; and
(2) Make provisions for continued reporting of data during change/test period so that data submission complies with R.19-810C.
H. To insure complete reporting, each hospital shall submit monthly, in writing, to the Office of Research and Statistics within forty-five days of the close of the month, a report of the number of inpatients discharged during the month (including newborns) and the number of inpatient days corresponding to those discharges. The hospital shall report using a format specified by the Office of Research and Statistics and provided to hospitals thirty days prior to implementation of the format.
I. The hospital's designee shall have access to the hospital's data elements in section R.19-810A.

19-820. Penalties for Failure to Meet Requirements.

A. Pursuant to South Carolina Code Section 44-6-170G, the Office may assess a civil fine for failure to comply with these regulations.

B. Failure to provide one record for each discharge (including newborns) according to R.19.810D or meet quality and item-completeness standards set forth in R.19.810E and R.19.910F.
(1) First occurrence: the Office of Research and Statistics shall notify the hospital Chief Executive Officer by certified letter of failure to comply. The hospital Chief Executive Officer shall reply in writing as to the reasons for non-compliance and provide a summary of measures implemented to insure future compliance. Full compliance shall occur within two subsequent monthly submissions;
(2) Subsequent occurrences: Fines may be followed as in subsection C. (2) below.
C. Failure to meet time frames for submission of required medical record extract information and supporting summary utilization data according to R.19.810D and R.19-810H or required financial and utilization items according to R.19.801A.
(1) The Office of Research and Statistics shall notify the hospital Chief Executive Officer by certified letter of failure to comply. The hospital shall be granted a two week grace period beginning on the date of the receipt of the letter.
(2) If the hospital fails to comply within the grace period:
(a) The Office of Research and Statistics shall notify the hospital Chief Executive Officer by certified letter of failure to comply. The Chief Executive Officer shall respond in writing to the Office of Research and Statistics within one week of date of receipt as to reasons for non-compliance.
(b) The Office of Research and Statistics may extend the grace period if it deems it warranted (as demonstrated by a good faith effort on the part of the hospital to comply) and shall notify the Chief Executive Officer in writing.
(c) Hospitals failing to comply within the grace period(s) may be fined as follows and the total fine may not exceed ten thousand dollars:
(i) First Occurrence $ 100
(ii) Second Occurrence $1,000
(iii) Third Occurrence $5,000
(d) A six-month grace period from the date these regulations become effective shall be granted by the Office of Research and Statistics before R.19.820 is enforced.
(e) The fines as levied as in C(2)(c) above shall be reset to “first occurrence” levels beginning three years from the date of first occurrence or upon change of ownership of the hospital or upon change of the hospital’s Chief Executive Officer.
D. The proposed penalties become the final agency decision within ten days after the certified letter to the administrator unless the Chief Executive Officer requests a reconsideration of the penalty in writing within the ten day grace period from the Executive Director of the Budget and Control Board or his/her designee. When such a request is submitted:
(1) The burden of proof for contested penalties will be upon the hospital; and
(2) The Executive Director of the Budget and Control Board or his/her designee must respond by certified letter to the Chief Executive Officer’s request within thirty days from the receipt of the request.

ARTICLE 10.

DATA REPORTING REQUIREMENTS PERTAINING TO SUBMISSION OF AMBULATORY ENCOUNTER DATA

(Statutory Authority: 1976 Code Section 44-6-170)

19-1001. Definitions.

Data Elements: refers to any specific characteristic, usually encoded, describing a patient, the services provided to a patient, the health care facility, and/or the professional rending the services, during a medical encounter.

Outpatient: refers to any person receiving care in a health care setting that does not require admission to a hospital. This definition includes observation patients.
Ambulatory Encounter Level Data: refers to data gathered or organized by each episode of medical care provided to an outpatient in a health care setting.
Health Care Setting: includes but is not limited to hospitals, ambulatory surgical facilities, home health agencies and providers of the following ambulatory services: radiation therapy, cardiac catheterization, lithotripsy, magnetic resonance imaging and positron emission therapy and other providers offering services with equipment requiring a Certificate of Need.

19-1010. Health Care Providers Required to Report Ambulatory Encounter Level Data to the Office of Research and Statistics.

A. Hospital based and freestanding Ambulatory Surgical Facilities as defined by the State Certificate of Need and Health Facility Licensure Act, Section 44-7-130.
B. Hospital Emergency Department included in a licensed facility under the State Certification of Need and Health Facility Licensure Act, Section 44-7-130.
C. Hospitals providing observation services for outpatients.
D. Any health care setting providing on an outpatient basis the following services: radiation therapy, cardiac catheterizations, lithotripsy, magnetic resonance imaging and positron emission therapy. Additionally, any other provider offering services with equipment requiring a Certificate of Need is required to report to the Office of Research and Statistics.
E. Home health agencies licensed under the "Licensure of Home Health Agencies Act."

19-1020. Medical Record Extract Information.

A. Ambulatory encounter level data for all outpatients shall be coded in accordance with**,** but not limited to, the specifications promulgated Secretary of the Department of Health and Human Services for the United States of America in accordance with the authority to designate health care codes and transactions under the Health Insurance Accountability and Portability Law of 1996 (HIPAA), as well as under the specifications of the Director of the Centers for Medicare and Medicaid Services and as specified in Medically Indigent Assistance Act for the State of South Carolina.
B. Data elements to be reported will be specified by the Data Oversight Council through *Principles and Protocol for the Release of Health Care Data.* The*Principles and Protocol for the Release of Health Care Data's* process for identifying data elements to be reported will include means for review and input by interested parties taking into consideration all applicable federal and state laws and regulations. The Data Oversight Council will rely, to the extent possible, on data elements currently being reported among health care entities.
C. Ambulatory encounter level data for all outpatients shall be submitted directly to the Office of Research and Statistics and provided to health care providers one hundred twenty days prior to implementation of that format.

19-1030. Criteria for Data Submission Timeliness and Items Completeness and Accuracy.

A. One record for each outpatient ambulatory encounter during the calendar month shall be submitted. Health care providers covered by these regulations shall submit at least ninety percent of their monthly ambulatory patient encounter records within forty-five days after the close of the month with exception made for conditions beyond the health care provider's control. Health care providers covered by these regulations shall submit one hundred percent of their patient encounter records within forty-five days after the close of the following month with exception made for conditions beyond the health care provider's control.
B. Reporting of required items shall meet ninety-nine percent item completeness.

C. Completed items shall meet ninety-nine and five-tenths percent accuracy as determined by edit specifications set by the Office of Research and Statistics.
D. Health care providers covered by these regulations changing hardware/software or processors which would necessitate a change in submission procedure shall:
(1) Notify the Office of Research and Statistics in writing at least sixty days prior to change and submit a test tape meeting completeness and accuracy requirements within one hundred twenty days after the change is accomplished,
(2) Make provisions for continued reporting of data during change/test period so that data submission complies with these regulations.
E. To insure complete reporting, each health care provider covered by these regulations shall submit monthly, in writing, to the Office of Research and Statistics within forty-five days of the close of the month, a report of the number of patient encounters during the month. The health care providers covered by these regulations shall report this information in a format specified by the Office of Research and Statistics and provided to health care providers thirty days prior to implementation of the format.
F. The Office of Research and Statistics will work with individual health care providers to incorporate the inclusion of data elements that are not currently coded into a standard data format during the modification period. The modification period will be for one year from the beginning submission date. See Section 19.1020. The modification period may be extended by Office of Research and Statistics based on changing federal reporting requirements.

19-1040. Penalties for Failure to Meet Timeliness, Completion and Accuracy Requirements.

A. Pursuant to South Carolina Code Section 44-6-170 G, the Office may assess a civil fine for failure to comply with these regulations.
B. Failure to provide one record for each patient encounter according to these regulations or meet accuracy and item-completeness standards set forth in these regulations:
(1) First occurrence: the Office of Research and Statistics shall notify the health care provider by certified letter of failure to comply. The health care provider shall reply in writing as to the reasons for non-compliance and provide a summary of measures implemented to insure future compliance. Full compliance shall occur within two subsequent monthly submissions;
(2) Subsequent occurrences: fines may be followed as in subsection C (2) below.
C. Failure to meet time frames for submission of required medical record extract information:
(1) The Office of Research and Statistics shall notify the health care provider by certified letter of failure to comply. The health care provider shall be granted a two-week grace period beginning on the date of the receipt of the letter.
(2) If the health care provider fails to comply within the grace period:
(a) The Office of Research and Statistics shall notify the health care provider by certified letter of failure to comply. The health care provider shall respond in writing to the Office of Research and Statistics within one week of date of receipt as to reasons for non-compliance.
(b) The Office of Research and Statistics may extend the grace period if it deems it warranted (as demonstrated by a good faith effort on the part of the health care provider), and shall notify the health care provider in writing.
(c) Health care providers covered by these regulations failing to comply within the grace period(s) may be fined as follows and the total fine may not exceed ten thousand dollars:
(i) First occurrence $ 100
(ii) Second occurrence $1,000
(iii) Third occurrence $5,000
A six-month grace period from the date these regulations become effective shall be granted by the Office of Research and Statistics before these regulations are enforced.

The fines as levied in C (2)(c) above shall be reset to "first occurrence" levels beginning three years from the date of first occurrence, or upon change of ownership of the health care provider, or upon change of the chief executive officer.
D. The proposed penalties become the final agency decision within ten days after the certified letter to the administrator unless the health care provider requests a reconsideration of the penalty in writing within the ten day grace period from the Executive Director of the Budget and Control Board or his/her designee. When such a request is submitted:
(1) The burden of proof for contested penalties will be upon the health care provider; and
(2) The Executive Director of the Budget and Control Board or his/her designee must respond by certified letter to the health care provider's request within thirty days from the receipt of the request.

19-1050. Criteria for the Release of Ambulatory Encounter Level Data.

The data collected under these regulations are subject to Final Regulations State Budget and Control Board Chapter 19, Statutory Authority: 1976 Code Section 44-6-170, Article 11, "Data Release For Medical Ambulatory Encounter Date & Financial Reports" providing for the release of medical encounter data.

19-1060. Confidentiality of Patient and Health Care Provider Identities.

A. The data collected under these regulations are subject to the confidentiality provisions of Section 44-6-170, as amended, Code of Laws of South Carolina, 1976, and in Final Regulations, State Budget and Control Board, Chapter 19, Statutory Authority: 1976 Code Section 44-6-170, Article 11, "Data Release For Medical Encounter Data & Financial Reports."
B. Failure to comply with confidentiality provisions in these regulations can result in legal action as specified in Section 44-6-180, as amended, Code of Laws of South Carolina, 1976.

ARTICLE 11.

DATA RELEASE FOR MEDICAL ENCOUNTER DATA & FINANCIAL REPORTS

(Statutory Authority: 1976 Code Section 44-6-170)

19-1101. Definitions.

Data Element: refers to any specific characteristic, usually encoded, describing a patient, the services provided to a patient or the health care facility, and/or the professional providing the services, during a medical encounter.
Encounter Level Data: refers to data gathered or organized by each contact between a patient and a health care professional in which care was given.
Health Care Facility: includes but is not limited to acute care hospitals, psychiatric hospitals, alcohol and substance abuse hospitals, tuberculosis hospitals, nursing homes, kidney disease treatment centers, including freestanding hemodialysis centers, ambulatory surgical facilities, rehabilitation facilities, residential treatment facilities for children and adolescents, habitation centers for mentally retarded persons or persons with related conditions, and any other freestanding facility offering services or special equipment for which Certificate of Need review is required by state law. For the purposes of this document, Home Health Agencies are included as defined by "Licensure of Home Health Agencies Act," as a public, nonprofit or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.
Health Care Facility Identifiers: the name, address, and/or identification number of a health care facility.

Health Care Insurer: includes but is not limited to domestic and foreign insurers providing accident and health insurance as defined by 38-1-20 of South Carolina Codes of laws, excluding federal and state insurers fund through public funds, including but not limited to, Medicare and Medicaid.
Health Care Insurer Identifiers: the name, address, and/or identification number of a health care insurer.
Health Care Professional: includes but is not limited to physician, physicians assistant, dentist, dental hygienist, dental technician, pharmacist, physical therapist, physical therapists assistant, optometrist, psychologist, respiratory care practitioner, registered nurse, licensed practical nurse, podiatrist, occupational therapist or other health care professional registered or licensed and practicing in South Carolina.
Health Care Professional Identifiers: the name, address, and/or identification number of a health care professional.
Research: means a planned and systematic sociological, psychological, epidemiological, biomedical, economic or other scientific investigations carried out by a government agency, by a scientific research professional associated with a bona fide scientific research organization, by a graduate student currently enrolled in an advanced academic degree curriculum, or other organizations with bona fide research capabilities with an objective to contribute to scientific knowledge, the solution of social and health problems, or the evaluation of public benefit and service programs. This definition excludes methods of record analysis and data collections that are subjective, do not permit replication, and are not designed to yield reliable and valid results.

19-1110. Data Oversight Council Authority.

A. The Data Oversight Council (DOC) shall classify data elements received by the Office of Research and Statistics (ORS) from health care facilities and/or professionals. The Data Oversight Council will rely, to the extent possible, on data elements currently being reported among health care entities.
B. The DOC shall establish the Data Release Protocol and make final decisions concerning the release of these data. The *Principles and Protocol for the Release of Health Care Data's* process for identifying data elements to be reported will include means for review and input by interested parties taking into consideration all applicable federal and state laws and regulations.
C. The DOC shall determine reports and electronic formats of data to be released for public use.
D. The DOC shall review and approve procedures for the ORS to use in protecting the confidentiality of the patient, health care facility, health care professional, and health insurers, excluding Medicare, Medicaid and any other governmental health insurers.

19-1120. Classification of Data Elements.

A. The data elements are classified into four categories: encounter-level, restricted, confidential, and never releasable. These categories are defined as:
(1) Encounter-level data are those data elements that are available for general public use.
(2) Restricted data are those data elements that require approval for release through the Data Release Protocol.
(3) Confidential data elements are those that shall be released only if a mandate has been established by statutory law.
(4) Never releasable data elements are those that may be used for statistical linking purposes only.
B. Until data elements are classified, they shall be considered restricted data and shall be subject to the Data Release Protocol.
C. To insure the confidentiality of patients, health care facilities, health care insurer and/or health care professionals certain data elements shall be classified by these regulations as Restricted, Confidential, or Never Releasable data elements. Restricted data elements include, but are not limited to, health care facility identifiers, health care professional identifiers, health care insurer identifiers, patient medical record number or chart number, and unique patient number. Confidential data elements include, but are

not limited to, patient name and address (excluding all Mental Health and Alcohol and other Drug Abuse encounters). Never releasable data elements include, but are not limited to, patient social security number (for all encounters), patient name and address for all Mental Health and Alcohol and other Drug Abuse encounters as required by federal law, and any other patient identifying information protected from release by federal law. All identifiers may be released back to the entity providing the data or controlling the enumeration of the data.

19-1130. Data Release Protocol.

A. The confidentiality of the patient shall be of the utmost concern. The release or re-release of data, in raw or aggregate form, that can be reasonably expected to reveal the identity of an individual patient shall be made only when a mandate has been established by statutory law.
B. Requests for the release of encounter-level and/or restricted data elements for research purposes shall be subject to the Data Oversight Council's Data Release Protocol.
C. The release of encounter-level**,** restricted and/or confidential data elements require that a confidentiality contract be signed by the appropriate individuals as specified in the *Principles and Protocol for the Release of Health Care Data* for each classification of data.
(1) These Confidentiality Contracts shall protect the confidentiality of the patient, health care facility, health care provider and health insurer and shall be specified in the *Principles and Protocol for the Release of Health Care Data* by the Data Oversight Council.
(2) These data are the property of the ORS and must be surrendered upon direction of the DOC.
(3) Failure to comply with the Confidentiality Contract may result in legal action. A person violating this section is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than one year, or both.
D. The DOC shall review requests for the release of encounter-level**,** restricted and/or confidential data for non-research purposes and make a final determination about the release of data.
E. Reports to be released for public use must follow the procedures and formats published in *The Principles and Protocol for the Release of Health Care Data*: *The Principles and Protocol for the Release of Health Care Data* shall allow for review and input by affected parties on the reports to be released for public use, taking into consideration all applicable federal, state laws and regulations.